

1158 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEAL ISLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEAL ISLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HER HOME</u>		d. STREET ADDRESS <u>1 MAIN ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>ALMA</u> Middle <u>ABBOTT</u> Last <u>ABBOTT</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR-19-1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEHOLD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEHOLD DUTIES</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM C. ABBOTT</u>	
14. MOTHER'S MAIDEN NAME <u>VIRGINIA WEBSTER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MOLLIE WEBSTER DEAL ISLAND MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia Hypersplenism</u> <u>298.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anemia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-28-58</u> , 19 <u>58</u> , to <u>1-25-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-25-60</u> , 19 <u>60</u> , and that death occurred at <u>1:15 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Everett C. Sutter</u>		M.D. <u>Dames Quarter, Maryland</u> DATE SIGNED <u>1-26-60</u>	
PHYSICIAN'S NAME (Type) <u>Everett C. Sutter MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JAN 27 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>DEAL ISLAND MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. S. Webster Deal Island</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 1 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED NAME ALMA		SEX FEMALE		RACE WHITE	
DATE OF BIRTH 1900		PLACE OF BIRTH ALABAMA		US BIRTH YES	
DATE OF DEATH 1910		PLACE OF DEATH ALABAMA		US DEATH YES	
CAUSE OF DEATH DISEASE		MANNER OF DEATH NATURAL		REPORTED BY PHYSICIAN	
SIGNATURE OF PHYSICIAN J. H. HARRIS		SIGNATURE OF DECEASED ALMA		SIGNATURE OF WITNESS J. H. HARRIS	
CITY ALABAMA		COUNTY ALABAMA		STATE ALABAMA	
ZIP CODE 36000		DISTRICT ALABAMA		CENSUS TRACT ALABAMA	
MARITAL STATUS SINGLE		OCCUPATION ALABAMA		EDUCATION ALABAMA	
RELIGION ALABAMA		ETHNICITY ALABAMA		ANCESTRY ALABAMA	
SOCIAL SECURITY NUMBER ALABAMA		MEDICAL INSURANCE ALABAMA		LIFE INSURANCE ALABAMA	
SIGNATURE OF DECEASED ALMA		SIGNATURE OF WITNESS J. H. HARRIS		SIGNATURE OF PHYSICIAN J. H. HARRIS	
CITY ALABAMA		COUNTY ALABAMA		STATE ALABAMA	
ZIP CODE 36000		DISTRICT ALABAMA		CENSUS TRACT ALABAMA	
MARITAL STATUS SINGLE		OCCUPATION ALABAMA		EDUCATION ALABAMA	
RELIGION ALABAMA		ETHNICITY ALABAMA		ANCESTRY ALABAMA	
SOCIAL SECURITY NUMBER ALABAMA		MEDICAL INSURANCE ALABAMA		LIFE INSURANCE ALABAMA	

1159 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>SOMERSET</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHANCE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHANCE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HER HOME</u>				d. STREET ADDRESS <u>MAIN ROAD</u>			
3. NAME OF DECEASED (Type or print) First <u>MAMIE</u> Middle <u>BECKETT</u> Last <u>BECKETT</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 12, 1882</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u>19</u> Min. <u>60</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>14</u> Hours <u>19</u> Min. <u>60</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Household</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Household</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>PETER WHITE</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>John Curtis</u> Address <u>Chance Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis</u> <u>340.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-13-60</u> , 19 <u>60</u> , to <u>1-14-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-14-60</u> , 19 <u>60</u> , and that death occurred at <u>6A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Everett C. Sutter</u> M.D.				ADDRESS (Street, city or town, state) <u>Dames Quarter, Maryland</u>			
DATE SIGNED <u>1-16-60</u>							
PHYSICIAN'S NAME (Type) <u>Everett C. Sutter MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>JAN 17-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Charles Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Chance Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. S. Webster</u> ADDRESS <u>Deed Island</u>				24a. REC'D BY REGISTRAR <u>Jan 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WILLIAM J. BROWN

WILLIAM J. BROWN
WILLIAM J. BROWN
WILLIAM J. BROWN

NAME		WILLIAM J. BROWN	
AGE		45	
SEX		Male	
RACE		White	
DATE OF BIRTH		1910	
PLACE OF BIRTH		Baltimore, Maryland	
OCCUPATION		Teacher	
CAUSE OF DEATH		Heart Disease	
DATE OF DEATH		1955	
PLACE OF DEATH		Home	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF WITNESS		[Signature]	
SIGNATURE OF DEATH REGISTRAR		[Signature]	

1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his last illness or who has attended him at the time of death.

2. The cause of death should be stated in as many words as possible, giving the immediate cause, the intermediate cause, and the remote cause, if known.

3. The date of death should be stated in full, including the day, month, and year.

4. The place of death should be stated in full, including the street, city, county, and State.

5. The occupation of the deceased should be stated in full.

6. The signature of the physician or other qualified person who has attended the deceased during his last illness or who has attended him at the time of death, and the signature of the death registrar, must be written in ink.

7. This certificate is to be filed in the office of the death registrar, who will issue a certificate of death to the family of the deceased.

8. A copy of this certificate will be sent to the State Department of Health, Baltimore, Maryland.

1160 CERTIFICATE OF DEATH

Reg. Dist. No.

01153

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD				c. LENGTH OF STAY IN 1b 52 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMORIAL HOSP.				d. STREET ADDRESS MARINER'S ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARLAN Middle BYRD Last BYRD				4. DATE OF DEATH Month JANUARY Day 19 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-29-1907	
9. AGE (In years last birthday) 52		IF UNDER 1 YEAR Months 52 Days 52 Hours 52 Min. 52		IF UNDER 24 HRS. Months 52 Days 52 Hours 52 Min. 52			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE LIFE INSURANCE AGENT				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN H. BYRD				14. MOTHER'S MAIDEN NAME SUSAN EVANS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. EDNA BYRD, CRISFIELD, MARYLAND			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1958 to Jan , 19 60 , that I last saw the deceased alive on JAN. 19 , 19 60 , and that death occurred at 1:40 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) MAIN STREET DATE SIGNED ACTUAL SIGNATURE C. G. Rawley M.D. PHYSICIAN'S NAME (Type) C. G. RAWLEY, M.D. CRISFIELD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-22-1960		22c. NAME OF CEMETERY OR CREMATORY MARINER'S CEMETERY		22d. LOCATION (City, town, or county) (State) CRISFIELD MD.	
23. FUNERAL DIRECTOR'S SIGNATURE L. S. Webster Crisfield Md				24a. REC'D BY REGISTRAR JAN 26 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1160

DECEASED

RESIDENT

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01154

Reg. Dist. No.

1156

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>		c. LENGTH OF STAY IN lb <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>Beckford Ave., Ext'd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>William</u> Last <u>Collins</u>				4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 6, 1959</u>	
9. AGE (In years last birthday) yrs. <u>3</u> Months <u>13</u> Days <u>13</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Princess Anne, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Gilbert H. Walston</u>			
14. MOTHER'S MAIDEN NAME <u>Madeline Collins</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Gilbert H. Walston - Princess Anne, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>a. m.</u> <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. H. Johnson</u>				DATE SIGNED <u>Jan. 19, 1960</u>			
EXAMINER'S NAME (Type) <u>R. H. Johnson, M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-20-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Johnson Jr.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01155

1152 Items 8, 9, 11, 14, 25, 2-5-60 et

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD	
c. LENGTH OF STAY IN 1b LIFETIME		d. STREET ADDRESS W. BROAD STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION W. BROAD ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle MILTON Last DAVIS		4. DATE OF DEATH Month JANUARY Day 18 Year 1960	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1896
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAFOOD WORKER		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY DAVIS		14. MOTHER'S MAIDEN NAME ---	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 217-05-8099	
17. INFORMANT JOHN HENRY BROWN		Address CRISFIELD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic Myocarditis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Passive Congestion DUE TO (c) Arteriosclerotic Heart Disease - Hypertension		INTERVAL BETWEEN ONSET AND DEATH few hours 18 mo Known 20 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Alcoholism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/13 19 59 to 1/18 19 60 that (I) (we) lost the deceased alive on 12/22 19 59 , and that death occurred at 4:00 AM , from the causes and on the date stated above.			
22a. SIGNATURE A. N. Barr, M.D.		22b. DATE SIGNED 1/25/60	
22c. PHYSICIAN'S NAME (Type) DR. A. N. BARR		22d. ADDRESS CRISFIELD, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 20, 1960	
23c. NAME OF CEMETERY OR CREMATORY LAWSONIA CEMETERY		23d. LOCATION (City, town, or county) (State) CRISFIELD, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	
ADDRESS CRISFIELD, MD.		25a. REC'D BY REGISTRAR DATE FEB 1 '60	

1152

RECEIVED

CHIEF OF BUREAU

NOV 10 1910

TO THE

CHIEF OF BUREAU

NOV 10 1910

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01156

Reg. Dist. No.

1161

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL MARION</u>		c. LENGTH OF STAY IN 1b <u>All his life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 171</u>		e. STREET ADDRESS <u>Box 171</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>DENNIS</u> Last <u>DENNIS</u>		4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-16-1887</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min. <u>73</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>P. DENNIS</u>		14. MOTHER'S MAIDEN NAME <u>Julia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>184-09-7956</u>	
17. INFORMANT <u>Mrs. Beulah DENNIS - MARION, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>Acute Dil. of Heart, Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis - C. Int. Nephritis</u> DUE TO (c) <u>about 4 years.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 9, 1959</u> , to <u>Jan. 26, 1960</u> , that I lost s/he the deceased on <u>Jan. 26, 1960</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George C. Coulbourn</u>		ADDRESS (Street, city or town, state) <u>Marion Station, Maryland</u> DATE SIGNED <u>1-29-60</u>	
PHYSICIAN'S NAME (Type) <u>George C. Coulbourn, M.D.</u>		<u>Marion Station, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-31-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Family Cem</u>		22d. LOCATION (City, town, or county) (State) <u>MARION, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Incenton B. Selley</u>		ADDRESS <u>Salisbury md</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carroll S. Kenna</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1157 CERTIFICATE OF DEATH

Reg. Dist. No.

01157

1. PLACE OF DEATH o. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Herbert Middle R. Last Dryden		4. DATE OF DEATH Month January Day 30 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 14 Hours 14 Min.	11. IF UNDER 24 HRS. Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) railroad		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Rufus Dryden		14. MOTHER'S MAIDEN NAME Ida Long	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Hollis Dryden, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Senility		INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 10 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary Anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 58 to Jan. 30, 1960 , that I last saw the deceased alive on Jan. 30, 1960 , and that death occurred at 11:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A.C. Lewis		ADDRESS (Street, city or town, state) Princess Anne, Md.	
PHYSICIAN'S NAME (Type) A.C. Lewis, M.D.		DATE SIGNED 1/30/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/1/60	
22c. NAME OF CEMETERY OR CREMATORY Immanuel		22d. LOCATION (City, town, or county) (State) Princess Anne, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Dunman		ADDRESS Princess Anne, Md.	
24a. REC'D BY REGISTRAR FEB 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

STATEMENT OF DEATH

1937

Name of deceased		Sex		Age	
Date of death		Place of death		Cause of death	
Occupation		Education		Religion	
Marital status		Previous illness		Manner of death	
Signature of physician		Signature of informant		Signature of registrar	
Date of statement		Place of statement		Signature of registrar	

1162 CERTIFICATE OF DEATH

Reg. Dist. No.

01158

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sidney Middle B. Last Ennis		4. DATE OF DEATH Month January Day 31 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1887
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Sidney C. Ennis	
14. MOTHER'S MAIDEN NAME Rose Matthews		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.		INFORMANT Harvey Ennis Princess Anne, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) uremia		INTERVAL BETWEEN ONSET AND DEATH 59 days years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-30-59 , 19___, to 1-31-60 , 19___, that I last saw the deceased alive on 1-31-60 , 19___, and that death occurred at 6a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Everett C. Sutter		ADDRESS (Street, city or town, state) Dames Quarter, Maryland 21160	
PHYSICIAN'S NAME (Type) Everett C. Sutter MD		DATE SIGNED 2/1/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2/2/60	
22c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Pocomoke City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James H. H. H.		ADDRESS Princess Anne, Md.	
24a. REC'D BY REGISTRAR FEB 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1103

Decedent's Name: Harvey Elmer
Date of Death: January 31, 1950
Place of Death: Harvey Elmer

Age at Death: 73
Sex: Male
Race: White
Marital Status: Married

Occupation: None
Cause of Death: Heart Failure

Medical History: None
Manner of Death: Natural

Signature of Physician: [Signature]
Date: 1-31-50

Signature of Coroner: [Signature]
Date: 1-31-50

Signature of Registrar: [Signature]
Date: 1-31-50
City: Harvey Elmer
County: Harvey Elmer

1163 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 CRISFIELD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMO. HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GORDON Carroll EVANS		4. DATE OF DEATH Month Day Year JANUARY 3 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-93
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE OWNER		10b. KIND OF BUSINESS OR INDUSTRY CONFECTIONERY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIE A. EVANS		14. MOTHER'S MAIDEN NAME Elpertena Tyler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1	
17. INFORMANT KENNETH EVANS		Address CRISFIELD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Cardiac Infarction DUE TO (b) Coronary Thrombosis DUE TO (c) Hypertension, on atherosclerosis			INTERVAL BETWEEN ONSET AND DEATH 1 wk 2 wks ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 22, 1959 , to Jan. 3, 1960 that I last saw the deceased alive on JAN. 3, 1960 , and that death occurred at 2:35 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah M. Peyton M.D.		ADDRESS (Street, city or town, state) CRISFIELD, MD.	
PHYSICIAN'S NAME (Type) SARAH M. PEYTON, M.D.		CRISFIELD, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-6-60	22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR JAN 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kinner	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1183 CERTIFICATE OF DEATH

1924

3 DAYS

11-11-24

11-11-24

11-11-24

11-11-24

11-11-24

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1153

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>				c. LENGTH OF STAY IN 1b <u>LIFETIME</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELMER REEVE GANDY</u>				4. DATE OF DEATH Month Day Year <u>JAN 12 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG.-15-1872</u>	
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED SEAFOOD PACKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ELMER REEVE GANDY-SR</u>				14. MOTHER'S M maiden NAME <u>MARY GANDY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>MRS BESSIE GANDY-CRISFIELD MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>334X</u> DUE TO (c) <u>334X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>334X</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs -</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 1959</u> , to <u>Jan 11 1960</u> , and that death occurred at <u>1228 M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11/4/60</u> DATE SIGNED <u>1/14/60</u>							
ACTUAL SIGNATURE <u>Sarah M. Peyton</u> M.D. <u>S. W. M. M. M.</u>							
PHYSICIAN'S NAME (Type) <u>Sarah M. Peyton</u> <u>Crisfield, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN 14-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SUNNYRIDGE MEMORIAL</u>		22d. LOCATION (City, town, or county) (State) <u>HOPEWELL MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Swisher</u> ADDRESS <u>Crisfield Md</u>				24a. REC'D BY REGISTRAR <u>1/18/60</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. & H. H. H.</u>	

21st Nov 1924

Grave old

Kilburn

London

at home

at 87

James

Robert

James

James

Male

Male

Retired

James

NO

James

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1164 CERTIFICATE OF DEATH

2 60A161

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. MARION STATION		c. LENGTH OF STAY IN 1b LIFETIME	
d. NAME OF HOSPITAL (If not in hospital, give street address) AT HOME		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BEULAH Middle GERTRUDE Last GREEN		4. DATE OF DEATH Month JANUARY Day 6 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 7, 1878
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) R.F.D. MARION STATION, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE WALSTON		14. MOTHER'S MAIDEN NAME MARZELLA MORRIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT ALLEN GREEN--		Address MARION STATION, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Dil. of Heart - Uremia - 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C. myocarditis - C. int. Nephritis DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 week years -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 25 1959 to Jan 6, 1960 , that (I) (we) last saw the deceased alive on Jan 6 - 1960 , and that death occurred at 1:05 PM , from the causes and on the date stated above.			
22a. SIGNATURE George C. Coulbourn		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN, M.D.		22d. ADDRESS MARION STATION, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 9, 1960	
23c. NAME OF CEMETERY OR CREMATORY ST. PEUL'S CEMETERY		23d. LOCATION (City, town, or county) (State) MARION STATION, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS--CRISFIELD, MD.		25a. REC'D BY REGISTRAR JAN 20 60	
25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

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DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01162

Reg. Dist. No.

1165

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manokin</u>		c. LENGTH OF STAY IN 1b <u>60 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		/d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Jones</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>January</u> Day <u>13</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/4/1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Blackstone, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Irene Ayers - Manokin, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis and Ch. Myocarditis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town), (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. H. Johnson, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/17/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul</u>	22d. LOCATION (City, town, or county) (State) <u>Revelles Neck-Westover, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Jones</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 15 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1166 CERTIFICATE OF DEATH

Reg. Dist. No. 261-

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westover		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Annr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Georgia Middle Kohlheim Last		4. DATE OF DEATH Month Jan , Day 1 , Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1889
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James W. Butler		14. MOTHER'S MAIDEN NAME Cora Townsend	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Mrs. Choley Ennis R.F.D. Westover, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Dil. of Heart. 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Int. Nephritis C. Hypertension DUE TO (c) from history of years.		INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sclerosis of Liver, General Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Dec. 30, 1959 to Jan. 1, 1960 , that I last saw the deceased alive on Jan. 1, 1960 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Marion Station, Maryland DATE SIGNED Marion St. and		
ACTUAL SIGNATURE George C. Coulbourn M.D. Marion St. and		
PHYSICIAN'S NAME (Type) George C. Coulbourn MARION STATION, MARYLAND		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/4/59	22c. NAME OF CEMETERY OR CREMATORY Monie
22d. LOCATION (City, town, or county) (State) Venton, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE James H. Hannon		24a. REC'D BY REGISTRAR JAN 12 '60
ADDRESS Princess Anne, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hannon

1933

WILLIAM ROSSIGNOL + JANE

Georgia
White
Married

James A. Rossignol
Mrs. Choley White R.R. 2, Rossignol, Ga.

James A. Rossignol
Mrs. Choley White R.R. 2, Rossignol, Ga.

James A. Rossignol
Mrs. Choley White R.R. 2, Rossignol, Ga.

James A. Rossignol
Mrs. Choley White R.R. 2, Rossignol, Ga.

James A. Rossignol
Mrs. Choley White R.R. 2, Rossignol, Ga.

James A. Rossignol
Mrs. Choley White R.R. 2, Rossignol, Ga.

1167 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Somerset</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Somerset</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Cristfield</i>		c. LENGTH OF STAY IN 1b <i>life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Asbury Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Hattie</i> Middle <i>H</i> Last <i>Lawson</i>		4. DATE OF DEATH Month <i>January</i> Day <i>12</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 14 1882</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>12</i> Hours <i>12</i> Min.	11. IF UNDER 24 HRS. Hours <i>12</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md.</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Thomas Dougherty</i>		14. MOTHER'S MAIDEN NAME <i>Mary Moore</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>INFORMANT Mrs. Maxwell Tyler Cristfield Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Angina pectoris</i> DUE TO (c) <i>Arterio-sclerotic myocardial disease</i>			INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>years -</i> <i>years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>April</i> , 19 <i>47</i> , to <i>Jan 12</i> , 19 <i>60</i> that I last saw the deceased alive on <i>Jan 9</i> , 19 <i>60</i> , and that death occurred at <i>6:24</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>C. Rawley</i>		ADDRESS (Street, city or town, state) <i>Cristfield Md.</i>	
PHYSICIAN'S NAME (Type) <i>C. Rawley</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/15/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Sonnyridge</i>	22d. LOCATION (City, town, or county) (State) <i>Hopewell Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James L. Hannon</i>		24a. REC'D BY REGISTRAR <i>Jan 18 '60</i>	
ADDRESS <i>Cristfield Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hannon</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1913

Decemr 20 1913
No. 12
Mary Moore
The above named person died at her residence
in the town of North Andover, Mass.
on the 20th day of December, 1913, at the age of 72 years.
The cause of death was
Senile Dementia.
The deceased was a native born female,
single, and had no children.
The deceased was a member of the
First Church of Christ and the
Disciples, North Andover, Mass.
The deceased was a widow.
The deceased was a native born female,
single, and had no children.
The deceased was a member of the
First Church of Christ and the
Disciples, North Andover, Mass.
The deceased was a widow.
The deceased was a native born female,
single, and had no children.
The deceased was a member of the
First Church of Christ and the
Disciples, North Andover, Mass.
The deceased was a widow.

Witness my hand and the seal of the Department of Health
this 21st day of December, 1913.
Attest:
John J. ...
Secretary of the Department of Health
The above certificate is true and correct as the same appears from the records of the Department of Health.
Witness my hand and the seal of the Department of Health
this 21st day of December, 1913.
Attest:
John J. ...
Secretary of the Department of Health
The above certificate is true and correct as the same appears from the records of the Department of Health.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1154 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1154 CERTIFICATE OF DEATH

01165

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b LIFETIME	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION COVE ST.		d. STREET ADDRESS 1 COVE ST.	
3. NAME OF DECEASED (Type or print) First ANNIE Middle ELIZA Last LEWIS		4. DATE OF DEATH Month JANUARY Day 8 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 29, 1887
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10b. KIND OF BUSINESS OR INDUSTRY CLOTHING MFG.	
11. BIRTHPLACE (State or foreign country) CRISFIELD, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SIDNEY K. TYLER		14. MOTHER'S MAIDEN NAME ANNA HORNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT ROY LEWIS--COVE ST.--CRISFIELD, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio-vascular arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH minutes years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 9:40 PM to Feb 1957 , that (I) (we) last saw the deceased alive on 2 19 7 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE C. G. Rawley		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) C. G. RAWLEY, M.D.		22d. ADDRESS MAIN ST. -- CRISFIELD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 11, 1960	
23c. NAME OF CEMETERY OR CREMATORY SUNNYRIDGE CEMETERY		23d. LOCATION (City, town, or county) (State) CRISFIELD, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS-- CRISFIELD, MD.		25a. REC'D BY REGISTRAR JAN 15 '60	
25b. REGISTRAR'S SIGNATURE Arthur E. Hanna			

CERTIFICATE OF DEATH

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CHINESE DIVISION

CERTIFICATE OF DEATH

Reg. Dist. No.

01166

1168

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne		c. LENGTH OF STAY IN lb life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George J. Middle Riggin Last		4. DATE OF DEATH Month January Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1886
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward T. Riggin		14. MOTHER'S MAIDEN NAME Grace Ruark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Mary Riggin RFD. Princess Anne		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 4 , 1960, to Jan 5 , 1960, that I last saw the deceased alive on Jan 4 , 1960, and that death occurred at 1:00 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Eldon G. Marksman M.D. Princess Anne, Md.			
ACTUAL SIGNATURE Eldon Marksman		PHYSICIAN'S NAME (Type) Eldon Marksman	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/8/60	
22c. NAME OF CEMETERY OR CREMATORY Perryhawkin		22d. LOCATION (City, town, or county) (State) R.F.D. Princess Anne, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Herman		ADDRESS Princess Anne, Md.	
24a. REC'D BY REGISTRAR JAN 12 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frame	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK

1887

County of ...

Know all men by these presents, that I, the undersigned, for and in behalf of the ...

George A. ...
... 1887 ...

Edward A. ...

... Mary ...

Witness my hand and seal this ... day of ... 1887.

... 1887 ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1169 CERTIFICATE OF DEATH

Reg. Dist. No. 01167

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ o. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD				c. LENGTH OF STAY IN 1b 18 mo.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 CRISFIELD				d. STREET ADDRESS JOHNSON CREEK ROAD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMORIAL HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ARTHUR Middle JAMES Last TYLER				4. DATE OF DEATH Month JANUARY Day 15 Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-1958		9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD JAMES TYLER				14. MOTHER'S MAIDEN NAME HAZEL MARSHALL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT		Address HAZEL TYLER, CRISFIELD, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 096.9 Violence inflicted by 7 Intoxicated DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 days							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 12, 1960 to Jan. 15, 1960 that I last saw the deceased alive on Jan. 15, 1960 , and that death occurred at 12:00 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND DATE SIGNED _____ ACTUAL SIGNATURE Sarah M. Peyton M.D. CRISFIELD, MARYLAND PHYSICIAN'S NAME (Type) SARAH M. PEYTON, M.D., CRISFIELD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 17, 1960		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons - - - Crisfield, Md.				24a. REC'D BY REGISTRAR DATE JAN 20 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1. NAME OF DECEASED: JOHN J. BROWN

2. SEX: Male

3. AGE: 45 Years

4. DATE OF DEATH: Jan 15 1911

5. PLACE OF DEATH: At Home

6. CAUSE OF DEATH: Heart Disease

7. PLACE OF BIRTH: Massachusetts

8. DATE OF BIRTH: Jan 15 1866

9. SEX OF DECEASED: Male

10. AGE OF DECEASED: 45 Years

11. PLACE OF DEATH: At Home

12. CAUSE OF DEATH: Heart Disease

13. PLACE OF BIRTH: Massachusetts

14. DATE OF BIRTH: Jan 15 1866

15. SEX OF DECEASED: Male

16. AGE OF DECEASED: 45 Years

17. PLACE OF DEATH: At Home

18. CAUSE OF DEATH: Heart Disease

19. PLACE OF BIRTH: Massachusetts

20. DATE OF BIRTH: Jan 15 1866

21. SEX OF DECEASED: Male

22. AGE OF DECEASED: 45 Years

23. PLACE OF DEATH: At Home

24. CAUSE OF DEATH: Heart Disease

25. PLACE OF BIRTH: Massachusetts

26. DATE OF BIRTH: Jan 15 1866

27. SEX OF DECEASED: Male

28. AGE OF DECEASED: 45 Years

29. PLACE OF DEATH: At Home

30. CAUSE OF DEATH: Heart Disease

31. PLACE OF BIRTH: Massachusetts

32. DATE OF BIRTH: Jan 15 1866

33. SEX OF DECEASED: Male

34. AGE OF DECEASED: 45 Years

35. PLACE OF DEATH: At Home

36. CAUSE OF DEATH: Heart Disease

37. PLACE OF BIRTH: Massachusetts

38. DATE OF BIRTH: Jan 15 1866

39. SEX OF DECEASED: Male

40. AGE OF DECEASED: 45 Years

41. PLACE OF DEATH: At Home

42. CAUSE OF DEATH: Heart Disease

43. PLACE OF BIRTH: Massachusetts

44. DATE OF BIRTH: Jan 15 1866

45. SEX OF DECEASED: Male

46. AGE OF DECEASED: 45 Years

47. PLACE OF DEATH: At Home

48. CAUSE OF DEATH: Heart Disease

49. PLACE OF BIRTH: Massachusetts

50. DATE OF BIRTH: Jan 15 1866

51. SEX OF DECEASED: Male

52. AGE OF DECEASED: 45 Years

53. PLACE OF DEATH: At Home

54. CAUSE OF DEATH: Heart Disease

55. PLACE OF BIRTH: Massachusetts

56. DATE OF BIRTH: Jan 15 1866

57. SEX OF DECEASED: Male

58. AGE OF DECEASED: 45 Years

59. PLACE OF DEATH: At Home

60. CAUSE OF DEATH: Heart Disease

61. PLACE OF BIRTH: Massachusetts

62. DATE OF BIRTH: Jan 15 1866

63. SEX OF DECEASED: Male

64. AGE OF DECEASED: 45 Years

65. PLACE OF DEATH: At Home

66. CAUSE OF DEATH: Heart Disease

67. PLACE OF BIRTH: Massachusetts

68. DATE OF BIRTH: Jan 15 1866

69. SEX OF DECEASED: Male

70. AGE OF DECEASED: 45 Years

71. PLACE OF DEATH: At Home

72. CAUSE OF DEATH: Heart Disease

73. PLACE OF BIRTH: Massachusetts

74. DATE OF BIRTH: Jan 15 1866

75. SEX OF DECEASED: Male

76. AGE OF DECEASED: 45 Years

77. PLACE OF DEATH: At Home

78. CAUSE OF DEATH: Heart Disease

79. PLACE OF BIRTH: Massachusetts

80. DATE OF BIRTH: Jan 15 1866

81. SEX OF DECEASED: Male

82. AGE OF DECEASED: 45 Years

83. PLACE OF DEATH: At Home

84. CAUSE OF DEATH: Heart Disease

85. PLACE OF BIRTH: Massachusetts

86. DATE OF BIRTH: Jan 15 1866

87. SEX OF DECEASED: Male

88. AGE OF DECEASED: 45 Years

89. PLACE OF DEATH: At Home

90. CAUSE OF DEATH: Heart Disease

91. PLACE OF BIRTH: Massachusetts

92. DATE OF BIRTH: Jan 15 1866

93. SEX OF DECEASED: Male

94. AGE OF DECEASED: 45 Years

95. PLACE OF DEATH: At Home

96. CAUSE OF DEATH: Heart Disease

97. PLACE OF BIRTH: Massachusetts

98. DATE OF BIRTH: Jan 15 1866

99. SEX OF DECEASED: Male

100. AGE OF DECEASED: 45 Years

101. PLACE OF DEATH: At Home

102. CAUSE OF DEATH: Heart Disease

103. PLACE OF BIRTH: Massachusetts

104. DATE OF BIRTH: Jan 15 1866

105. SEX OF DECEASED: Male

106. AGE OF DECEASED: 45 Years

107. PLACE OF DEATH: At Home

108. CAUSE OF DEATH: Heart Disease

109. PLACE OF BIRTH: Massachusetts

110. DATE OF BIRTH: Jan 15 1866

111. SEX OF DECEASED: Male

112. AGE OF DECEASED: 45 Years

113. PLACE OF DEATH: At Home

114. CAUSE OF DEATH: Heart Disease

115. PLACE OF BIRTH: Massachusetts

116. DATE OF BIRTH: Jan 15 1866

117. SEX OF DECEASED: Male

118. AGE OF DECEASED: 45 Years

119. PLACE OF DEATH: At Home

120. CAUSE OF DEATH: Heart Disease

121. PLACE OF BIRTH: Massachusetts

122. DATE OF BIRTH: Jan 15 1866

123. SEX OF DECEASED: Male

124. AGE OF DECEASED: 45 Years

125. PLACE OF DEATH: At Home

126. CAUSE OF DEATH: Heart Disease

127. PLACE OF BIRTH: Massachusetts

128. DATE OF BIRTH: Jan 15 1866

129. SEX OF DECEASED: Male

130. AGE OF DECEASED: 45 Years

131. PLACE OF DEATH: At Home

132. CAUSE OF DEATH: Heart Disease

133. PLACE OF BIRTH: Massachusetts

134. DATE OF BIRTH: Jan 15 1866

135. SEX OF DECEASED: Male

136. AGE OF DECEASED: 45 Years

137. PLACE OF DEATH: At Home

138. CAUSE OF DEATH: Heart Disease

139. PLACE OF BIRTH: Massachusetts

140. DATE OF BIRTH: Jan 15 1866

141. SEX OF DECEASED: Male

142. AGE OF DECEASED: 45 Years

143. PLACE OF DEATH: At Home

144. CAUSE OF DEATH: Heart Disease

145. PLACE OF BIRTH: Massachusetts

146. DATE OF BIRTH: Jan 15 1866

147. SEX OF DECEASED: Male

148. AGE OF DECEASED: 45 Years

149. PLACE OF DEATH: At Home

150. CAUSE OF DEATH: Heart Disease

151. PLACE OF BIRTH: Massachusetts

152. DATE OF BIRTH: Jan 15 1866

153. SEX OF DECEASED: Male

154. AGE OF DECEASED: 45 Years

155. PLACE OF DEATH: At Home

156. CAUSE OF DEATH: Heart Disease

157. PLACE OF BIRTH: Massachusetts

158. DATE OF BIRTH: Jan 15 1866

159. SEX OF DECEASED: Male

160. AGE OF DECEASED: 45 Years

161. PLACE OF DEATH: At Home

162. CAUSE OF DEATH: Heart Disease

163. PLACE OF BIRTH: Massachusetts

164. DATE OF BIRTH: Jan 15 1866

165. SEX OF DECEASED: Male

166. AGE OF DECEASED: 45 Years

167. PLACE OF DEATH: At Home

168. CAUSE OF DEATH: Heart Disease

169. PLACE OF BIRTH: Massachusetts

170. DATE OF BIRTH: Jan 15 1866

171. SEX OF DECEASED: Male

172. AGE OF DECEASED: 45 Years

173. PLACE OF DEATH: At Home

174. CAUSE OF DEATH: Heart Disease

175. PLACE OF BIRTH: Massachusetts

176. DATE OF BIRTH: Jan 15 1866

177. SEX OF DECEASED: Male

178. AGE OF DECEASED: 45 Years

179. PLACE OF DEATH: At Home

180. CAUSE OF DEATH: Heart Disease

181. PLACE OF BIRTH: Massachusetts

182. DATE OF BIRTH: Jan 15 1866

183. SEX OF DECEASED: Male

184. AGE OF DECEASED: 45 Years

185. PLACE OF DEATH: At Home

186. CAUSE OF DEATH: Heart Disease

187. PLACE OF BIRTH: Massachusetts

188. DATE OF BIRTH: Jan 15 1866

189. SEX OF DECEASED: Male

190. AGE OF DECEASED: 45 Years

191. PLACE OF DEATH: At Home

192. CAUSE OF DEATH: Heart Disease

193. PLACE OF BIRTH: Massachusetts

194. DATE OF BIRTH: Jan 15 1866

195. SEX OF DECEASED: Male

196. AGE OF DECEASED: 45 Years

197. PLACE OF DEATH: At Home

198. CAUSE OF DEATH: Heart Disease

199. PLACE OF BIRTH: Massachusetts

200. DATE OF BIRTH: Jan 15 1866

CERTIFICATE OF DEATH

Reg. Dist. No.

01168

1170

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Crisfield		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nancy Middle Elizabeth Last Ward		4. DATE OF DEATH Month January Day 27 , Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 24, 1893
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME George Mason	
14. MOTHER'S MAIDEN NAME Allen Cullen		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Harlan Tyler, Crisfield, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Concussion Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 days 5 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Jan 22, 1960 , to Jan 27, 1960 , that I last saw the deceased alive on Jan 27, 1960 , and that death occurred at 10 PM , from the causes and on the date stated above.	
ACTUAL SIGNATURE Sarah M. Peyton M.D. 33 W. Main		ADDRESS (Street, city or town, state) Crisfield, Md.	
DATE SIGNED 1/29/60		PHYSICIAN'S NAME (Type) Sarah M. Peyton Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/31/60	
22c. NAME OF CEMETERY OR CREMATORY Asbury		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Hannon		ADDRESS Crisfield, Md.	
24a. REC'D BY REGISTRAR DATE FEB 5 '60		24b. REGISTRAR'S SIGNATURE Orlino S. Hannon	

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

01108

CERTIFICATE OF DEATH

01108

DECEASED

NAME

DECEASED

John Doe

Age

John Doe

January 10, 1910

At the residence of

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01169

1155 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E. Chesapeake Ave.				d. STREET ADDRESS E. Chesapeake Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LUCY Middle JANE Last WILSON				4. DATE OF DEATH Month January Day 29 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 21, 1873	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Purnell Lawson				14. MOTHER'S MAIDEN NAME Melissa ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-05-8539		17. INFORMANT Address Mrs. Emma Ennis, Crisfield, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Hypertensive arteriosclerotic DUE TO (c) cardiovascular disease							INTERVAL BETWEEN ONSET AND DEATH 12 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Hyper trophic arthritis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Jan. 9, 1960 to Jan. 29, 1960 that (1) (we) last saw the deceased alive on Jan. 29, 1960 , and that death occurred at 4:45 PM , from the causes and on the date stated above.							
22a. SIGNATURE R. W. Ireland M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2 Feb 60	
22c. PHYSICIAN'S NAME (Type) R. W. Ireland, M. D.				22d. ADDRESS Crisfield, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 31, 1960		23c. NAME OF CEMETERY OR CREMATORY Mariners Cemetery		23d. LOCATION (City, town, or county) (State) Crisfield, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bradshaw & Sons, Crisfield, Maryland				25a. REC'D BY REGISTRAR DATE FEB 3 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

MEDICAL CERTIFICATION

01183

MASSACHUSETTS DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH - LABORATORY

CERTIFICATE OF DEATH

1155

Decedent's Name		John J. O'Connell	
Sex		Male	
Age		65	
Date of Birth		Jan. 21, 1893	
Place of Birth		Columbia, Maryland	
Usual Residence		123 Main St., Boston, Mass.	
Cause of Death		Heart Disease	
Date of Death		Jan. 25, 1955	
Place of Death		Home	
Physician's Name		Dr. J. H. Smith	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		Jan. 26, 1955	
Place of Registration		Boston, Mass.	